MARYLAND HEALTH QUALITY AND COST COUNCIL

Meeting Minutes
September 14, 2012

Members in Attendance: Secretary Joshua Sharfstein (Vice Chair), Jill Berger, Barbara Epke, Peggy O'Kane, Albert Reece, Jon Shematek, Kathleen White, and Christine Wray

Members Absent: Lt. Gov. Anthony Brown (Chair), James Chesley, Lisa Cooper, Richard "Chip" Davis, Roger Merrill, and Marcos Pesquera

Staff: Laura Herrera, Katie Jones, Russ Montgomery, and Frances Phillips

---

Welcome and Approval of Minutes

Secretary Sharfstein called the meeting to order at 9:30am. He welcomed the Council members and guests to the meeting and announced that the Lieutenant Governor was unable to attend. Minutes from the June 8, 2012 Council meeting were approved.

Medical Waste Workgroup – *Dr. Cliff Mitchell, Environmental Health Bureau, DHMH*

In a brief presentation, Dr. Cliff Mitchell outlined the workgroup's composition, charge, and progress to date. The workgroup includes representatives from hospitals, insurance companies, home health agencies and the waste management industry, as well as clinicians and experts in public and environmental health. The workgroup's charge is to consider mechanisms to reduce costs and improve quality associated with management of waste across the entire health care enterprise. This will include a variety of medical settings, not just hospitals.

At the workgroup's four meetings to date, members have reviewed industry segments and practices and defined questions and challenges to consider. These include legal and regulatory issues, costs of waste management, barriers to achieving best practices, and health impacts of waste exposure. They are also considering goals for reducing waste at one- and five-year time windows and ways to improve the quality of data on waste management. Recommendations are being developed and will be released in a report.

Value-Based Purchasing

Secretary Sharfstein introduced value-based purchasing (VBP) as a new topic of interest for the Council. After discussing high-deductible health plans at previous meetings, it was felt that VBP offers a feasible alternative and should be encouraged in the state. Russ Montgomery, Council staff, noted that there would be presentations on existing Maryland VBP initiatives, national trends in VBP, efforts of a large state-based employer, and opportunities for the state to further catalyze VBP efforts.

VBP Programs in Maryland – Guy D'Andrea, Discern Consulting

Guy D'Andrea was introduced by Mr. Montgomery. Mr. D'Andrea founded Discern Consulting in 2004. Since that time, he has worked with leading health care organizations nationwide to design, implement, and evaluate pay-for-performance and value-based purchasing strategies. Before starting Discern, he spent seven years as a vice president at URAC. He earned dual Masters of Business Administration degrees from Columbia University and the London Business School.

Mr. D'Andrea began by noting that the health care system is already full of incentives, and we need to alter existing incentives to promote value. We reward volume and complexity and are indifferent towards quality and outcomes. Value-based purchasing starts with defining desired system performance and then aligning payment and incentives with those goals. Incentives reside in the interaction between patients and providers, and there should be balance and a positive feedback loop between the two. Appropriate incentives can produce (1) consistent measures and accurate data, (2) more engagement in care process improvement, and (3) better outcomes and lower cost.

Maryland already has several VBP initiatives in place. The Health Services Cost Review Commission (HSCRC) administers several hospital VBP initiatives: the Quality Based Requirement (QBR), which reimburses based on quality measures; the Maryland Hospital-Acquired Conditions (MHAC) Initiative, which uses incentives based on hospitals' complication rates; and Admission-Readmission Revenue (ARR), which places hospitals at risk for the cost of readmissions. These HSCRC initiatives are in addition to VBP initiatives from Medicare, which Mr. D'Andrea stated are only affecting margins and are unlikely to significantly affect hospital operations.

Maryland also has two patient-centered medical home (PCMH) programs -- the Maryland Multi-Payer Program and the CareFirst program – which provide a foundation for further VBP initiatives. An example is P3, a program implemented by the University of Maryland School of Pharmacy that includes pharmacist-based chronic disease coaching and comprehensive medication therapy management. This program can be linked with PCMH to as part of a "medical neighborhood." Finally, eValue8 is a tool implemented locally by the Mid-Atlantic Business Group on Health. This tool is used to gather health plan data on health promotion, disease management, and payment. Plans and purchasers receive objective scores enabling comparison of plans against regional and national benchmarks.

Trends in Employer Value-Based Purchasing Activity – Michael Bailit, Bailit Health Purchasing

Mr. Montgomery introduced Michael Bailit of Bailit Health Purchasing as the next speaker. Mr. Bailit founded Bailit Health Purchasing in 1997 and has worked with a wide array of government agencies and purchasing coalitions. Prior to founding Bailit Health Purchasing, Michael served as the Assistant Commissioner of Medicaid in Massachusetts. Also while with Massachusetts, he founded the Massachusetts Healthcare Purchaser Group. Mr. Bailit earned an MBA from Northwestern University. He presented to the group via teleconference.

First, Mr. Bailit overviewed the role of employers as health purchasers. Because of this role, employers can have a major influence on health care delivery. Employer/purchasers include self-insured large employers (many of which are multi-state), state and other public

employee groups, mid-sized employers in self-insured and traditional plans, fully insured small employers, and employer coalitions. Their overwhelming concern is cost, with quality as a secondary concern. They have seen premiums grow annually by two to three times the rate of inflation for decades and have reacted to this growth by cost-shifting to employees, moving to "defined contribution," and dropping coverage. At the same time, leading employer/purchasers are incentivizing and supporting health behavior change and helping advance payment and delivery system reform. They have typically done this without state involvement, although some states have tried to support efforts through regulation and transparency investments.

Mr. Bailit discussed notable examples of purchasers incentivizing and supporting health behavior change. Incentives for such activities include earning contributions to health savings accounts. The State of Tennessee Employee Benefit Program allows members to choose from two insurance options, but incentivizes the option that requires health assessments, screenings, and wellness activities. The program also requires tobacco users to enroll in a cessation program, and members at risk for chronic diseases must enroll in disease management programs.

He also oulined four major purchasing strategies:

(1) Tiered and select networks. Tiered networks classify providers based on measures of efficiency and quality. Consumers pay higher costs for low-ranked providers. In "select" or "limited" networks, providers are "in" or "out" of network based on efficiency or quality. For example, the Massachusetts Group Insurance Commission phased in tiering over five years. They offered a 3-month premium holiday to those choosing select networks, resulting in 31% take-up.
(2) Value-based insurance design (VBID). In this approach, incentives for members are varied based on the value of a service, typically through co-pays. It is often used for chronic disease medications, and occasionally with health education and other preventive services.
(3) Empowering employees with information. For beneficiaries with high deductibles, some insurers are introducing tools to aid with decision-making. An example is UnitedHealthcare's "My Healthcare Cost Estimator," which provides comparative cost and quality information for treatments and procedures by provider.
(4) Risk-based contracting with providers. This approach allows a purchaser to contract directly with providers and pay one fee for a set of services for its covered population. In the large state employee plan in California, an agreement was reached between a physicians group, a hospital, and the payer to a shared-risk global payment to encourage care coordination. The agreement resulted in $15.5 million in savings in 2010. In Maine, the state employee plan negotiated a risk agreement with a large hospital and its affiliated physicians. $1 million was placed at-risk by the provider.

Marriott's Value Based Plan Designs – Jill Berger, Marriott Corporation

Council member Jill Berger provided the purchaser perspective by highlighting Marriott's experiences with VBP and lessons learned. Marriott's strategy has been to develop a sustainable wellness culture that encourages employees to take responsibility for managing their health and wellness. They provide employees with tools to help employees meet their goals. While they used to offer about 150 different health plans, they now offer three HMO

and two PPO plans. They have 156,000 covered lives and spend $500 million annually on health care. 70 percent are enrolled in HMOs, and most of their plans are self-insured.

One VBP solution they have used is value-based formularies. In place since 2005, their formulary offers co-pay reductions for certain medications in highly prevalent chronic conditions, such as ACE inhibitors and statins. They identify members at risk and communicate program details, while ensuring those that do not need the medications are not enrolled. A controlled study of the program found that it increased spending on prescription drugs while decreasing spending on non-drug services. This resulted in off-setting costs in year one, while subsequent years have seen cost savings.

More recently, they have tied the formulary program to disease management programs, and enrollment has been high. In addition, they offer free preventive care, free smoking cessation programs, as well as health assessments and health couch programs. As a next step, they are considering implementing tiered networks and other VBP programs.

State Government as a Catalyst for VBP – Guy D'Andrea

As a conclusion to presentations on VBP, Mr. D'Andrea outlined four roles state government can play to catalyze implementation of value-based purchasing programs:

(1) Purchaser. State governments themselves are major purchasers due to covering their own employees and administering Medicaid, CHIP, and – in the near future – health insurance exchanges. They may be able to implement VBP directly for these covered individuals.
(2) Regulator. Regulations can affect provider payment and consumer incentives. In Maryland, the hospital rate setting system provides a unique lever for implementing VBP. Most of the existing regulations were developed in a time when the goal was to separate health financing from health care delivery. We have since learned there is no way to break them apart. Innovations such as patient-centered medical homes are a step toward regulatory integration.
(3) Data provider. States have opportunities to provide data that can guide value-based decision-making. Multi-payer claims databases are an example of how data can be harnessed and presented in a useful way. Cost is a trailing indicator, however, and we need to develop leading indicators, such as predictions of future beneficiary spending.
(4) Convener. State governments have the ability to convene stakeholders and spread a consistent message. This allows for faster dissemination and scale-up of best practices.

Discussion

Peggy O'Kane stated that employers are in a great position to drive purchasing, and tiering can be very powerful. But she has concern that if you put a lid on one thing, costs may grow elsewhere. Another problem is that everyone is doing tiering differently. We need a set of standards for tiering and a common way to estimate the total cost of care. Jill Berger agreed, and said that difficulty costing is one of the reasons it took Marriott a while to implement tiering. She sees new VBP tools as what managed care was supposed to be in the 1990s. Barbara Epke asked Ms. Berger why Marriott has focused its efforts on consumers

instead of suppliers. She responded that they focus energy on where they have the most control.

Kathleen White asked Mr. D'Andrea about providing cost and quality data directly to consumers. Currently, it's not widely available, despite being foundational to incentive programs. He responded that it is necessary but not sufficient. Consumers often do have access to such data but don't have much incentive to use it. They also tend to view high-cost services as being high-quality services, which is often not the case. On the other hand, Ms. O'Kane stated that reference pricing has worked well in driving consumer decision-making. Jon Shematek stated that consumers and providers are two sides of the same coin. Employers have many opportunities to influence consumer behavior. He has seen these kinds of cost comparison tools, and Maryland is well positioned to further develop them.

Ms. O'Kane stated that Maryland needs a "value agenda." It's in the interest of providers to accept a value agenda because they do not want to sacrifice quality as they attempt to reduce costs. Maryland should become a leading example in its role as a convener, as described by Mr. D'Andrea, to convene employers – include small employers – and develop a value agenda. Payers should be aligned on common strategies, such as tiering. The difficulty comes from providers feeling threatened. From a provider perspective, Christine Wray pointed out that hospitals and other facilities must cover their own employees. They are very aware of these strategies, and want to "practice what we preach." They are already moving toward population health management in employee plans.

Secretary Sharfstein said that the Maryland Health Care Commission and the Evidence-Based Medicine Worgkroup should have one or two meetings on this topic prior to the next Council meeting in December. They can prioritize specific VBP issues and develop an agenda for moving VBP forward in the state.

Wellness and Prevention Workgroup – *Christine Wray, MedStar Health*

Christine Wray provided an update on the activities of the Wellness and Prevention Workgroup. DHMH and the Institute for a Healthiest Maryland have assessed optimal starting points for implementation of the Community Transformation Grant (CTG) in 17 locations across the state. Several local initiatives have already been implemented, including child care environments and tobacco free laws. Next steps include implementation of year two CTG activities.

She also provided an update on Healthiest Maryland Businesses (HMB). They have now reached a total of 170 businesses and a total of 260,000 employees. They have also held three training events, which have reached 425+ stakeholders. They will launch HMB "success stories" in December 2012 to spread best practices.

The State Employee Wellness Initiative is ongoing, as implementation of phase one continues. State agencies were convened in August 2012. A new focus will be on food procurement, and a workgroup is being formed for this initiative. The next step is to review the Department of Budget and Management's disease management report.

Ms. Wray then provided an update on the Million Hearts campaign. The workgroup has developed a Million Hearts action plan to serve as a framework for ongoing and future

campaign efforts. She distributed a handout of the plan and reviewed it with the Council. The action plan is available on the Health Quality & Cost Council website.

Million Hearts Activities at MedStar Health – Dr. Peter Basch, MedStar Health

Ms. Wray introduced Dr. Peter Basch, Medical Director for Ambulatory EHR and Health IT Policy at MedStar Health, who discussed the efforts across MedStar hospitals to implement Million Hearts. Dr. Basch practices general internal medicine and is providing the clinical and strategic leadership for MedStar's ambulatory EHR implementation. In addition, he is a Senior Fellow for Health IT Policy at the Center for American Progress and a Visiting Scholar at the Engelberg Center for Health Care Reform at the Brookings Institution.

Dr. Basch began by discussing how 10 percent of the nearly two million hearts attacks and stroked that occur annually in the U.S. could be prevented by the "ABCs:" Aspirin regimens, regular BP and lipid screenings, treating high blood pressure, and quitting smoking. He stated that MedStar decided to partner with Million Hearts as part of its increasing focus on prevention and its commitment to serving the community. He said that the "stars align" because of their world-class cardiology program, use of the ABCs, common EMR system, and successful use of state-1 meaningful use. Further, he stated that incorporating Million Hearts into practice is state-2 meaningful use, while success is state-3. They will be holding their PCPs accountable for ABC progress, use of EHRs, use of clinical decision supports, patient education and engagement, and related efforts over the next five years.

He noted that on October 1, 2012, they will launch a new EMR that contains modules on the ABCs, prompting physicians to discuss these issues with patients. Based on the PCPs input, patients will receive customized reports with their own goals and progress.

In addition, MedStar is engaging in community outreach, education, and research. This will include efforts to encourage healthier eating and exercise, taking on larger numbers of medical students and residents, and studying the effects of their Million Hearts efforts. They intend to calculate the number of heart attacks and stroked prevented.

He finished by highlighting short-term goals and next steps. They intend to have 100 percent adherence on ABCs in the near term. The EHR is key to reaching this goal. They will also focus on positive deviance (use of unorthodox practices that show positive outcomes), improving patient adherence, and implementing best smoking cessation practices.

Discussion

Jon Shematek praised Dr. Basch's presentation and asked about how their strategy works in practice. For instance, if someone presents with flu-like symptoms, will the ABCs still be a focus of the office visit? Dr. Basch responded that the chief complaint and the ABC protocols create a shared agenda. The focus of the visit should be on the chief complaint, and the provider may work-in prevention questions as appropriate. Sometimes there may be a nice segue from the patient's symptoms to prevention question. If not all the ABCs are addressed, they will be flagged for the next visit.

Dr. Laura Herrera, Chief Medical Officer at DHMH, said she often hears of "alert fatigue" from practicing physicians. If they are continually facing EHR prompts, they begin to ignore them. She said there is a fine line between actively listening to the patient and addressing all of the alerts. Similarly, Ms. O'Kane noted the findings of a recent study from Kaiser Permanente, which found that their doctors were unhappy with constant alerts after implementation a new Epic system. Since then, they've moved to a team-based approach where physician assistants and medical assistants are handling prevention-related questioning.

Dr. Basch responded that his colleagues do not view the system as overwhelming. Addressing the alerts should not be burdensome to PCPs if they are proactive and efficient. He acknowledged that some of these things could be addressed by allied health professionals in the practice, but he thinks that they deserve PCP attention. He concluded by pointing out that once the ABCs are discussed in earnest once, following-up takes little time.

Secretary Sharfstein thanked Dr. Basch and said that we may ask him to return to report on MedStar's progress.

Healthcare-Acquired Infections Prevention Efforts – *Drs. Lucy Wilson and David Blythe, Office of Infectious Disease Epidemiology and Outbreak Response, DHMH*

Drs. Lucy Wilson and David Blythe of DHMH presented an update on healthcare acquired infection (HAI) prevention efforts and progress-to-date in Maryland. HAIs, which are infections that patients acquire while receiving care for other conditions, account for an estimated 1.7 million infections and nearly 100,000 deaths in the U.S. annually. Bloodstream infections (BSIs), catheter associated urinary tract infections (CAUTIs), surgical sites infections (SSIs), and ventilator-associated pneumonia (VAP) account for more than 80 percent of all HAIs and are some of the most serious. There are 250,000 cases of central line-associated blood stream infections (CLABSIs) annually.

In 2009, the U.S. Department of Health and Human Services (HHS) released an HAI action plan, which includes a multi-factorial approach to surveillance, prevention, and control of HAIs. In Maryland, a law was passed in 2006 granting authority to collect and report HAIs. An advisory committee and the Maryland Health Care Commission (MHCC) developed the plan, which was submitted to HHS. It includes mandatory surveillance and public reporting of CLABSIs, SSIs, and health care worker flu immunization. The program aligns with the hand hygiene initiative. MHCC recently released its Hospital Performance Guide on CLABSIs. In FY11, there was a 37 percent reduction in CLABSI at all intensive care units (ICUs).

Dr. Wilson stated that next steps for this effort include assessing Maryland's infection prevention efforts. This will include antimicrobial stewardship, environmental cleaning, screening, isolation, infection control, and health care worker immunization. This assessment will drive interventions for improvement. They also plan to enhance current surveillance by targeting specific organisms and piloting new techniques and data collection mechanisms.

Discussion

Ms. O'Kane asked the presenters if there is a validation process for measuring CLABSIs. They stated that efforts are ongoing, but the validation process is painstaking. They are looking at what is working in other states based on information from the Centers for Disease Control and Prevention.

She also asked about the efforts for C-diff and other organisms. Dr. Wilson said that they are developing a more strategic approach that will allow them to target specific organisms. They have some ongoing pilot projects. Ms. O'Kane also said it would be interesting to see changes in rates over time for different organisms.

Cultural and Linguistic Competency Workgroup – *Dr. Carlessia Hussein, Office of Minority Health and Health Disparities, DHMH*

Dr. Carlessia Hussein provided a brief update on the activities of this workgroup. Senate Bill 234 required the Council to convene a workgroup to examine appropriate standards for cultural and linguistic competency for medical treatment and the feasibility and desirability of incorporating these standards into reporting by providers, tiering, and reimbursement rates. The workgroup must submit a report by December 2013.

The Office of Minority Health and Health Disparities (MHHD) will staff the workgroup. Dr. Hussein announced that Dr. Lisa Cooper will serve as chair and Dr. Marcos Pesquera the vice-chair of the workgroup. MHHD and the new leaders held a conference call in August 2012 to discuss plans for implementation. Nominations for the workgroup were solicited from the various stakeholder groups required in the legislation, and the newly formed workgroup will meet for the first time in October 2012.

Health Reform Update – *Dr. Joshua Sharfstein*

Secretary Sharfstein provided a brief update on state health reform efforts. Progress continues to be made on implementation of the health insurance exchange, which is being called the Maryland Health Connection. A website for the exchange was recently launched: http://www.marylandhealthconnection.gov.

Next Steps

Secretary Sharfstein reminded Council members that the next meeting is on December 9, 2012 from 9:30am to 12 noon at the UMBC Technology Center. The meeting adjourned at 11:56am.